IAPT Stakeholder Event
London/Leeds – November 2019
# Introductions

<table>
<thead>
<tr>
<th>NHS Digital</th>
<th>Welcome and Introductions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicholas Richman</td>
<td>IAPT v2.0: Changes, Support and Implementation</td>
</tr>
<tr>
<td>Aaron Leathley</td>
<td>Data Processing Services Update</td>
</tr>
<tr>
<td>Paul Arrowsmith</td>
<td>IAPT Provider Support</td>
</tr>
<tr>
<td>Ian Binns</td>
<td>IAPT Analysis and Reporting</td>
</tr>
<tr>
<td>Sharon Thandi</td>
<td>SNOMED CT Implementation in Mental Health</td>
</tr>
<tr>
<td>Denise Downs</td>
<td>IAPT Workforce Information</td>
</tr>
<tr>
<td>Nick Armitage</td>
<td></td>
</tr>
</tbody>
</table>

**Guest Speakers**

<table>
<thead>
<tr>
<th>Andrew Armitage</th>
<th>IAPT Programme update / Long Term Conditions/ Professional Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary Pappin</td>
<td>Perinatal Mental Health Policy Update</td>
</tr>
<tr>
<td>Kevin Jarman</td>
<td>Employment Advisors in IAPT</td>
</tr>
<tr>
<td>Rachel Heggart</td>
<td>Internet Enabled Therapies</td>
</tr>
</tbody>
</table>
## IAPT v2.0 – Roadmap recap

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 September 2019</td>
<td>Standard published by DCB Supporting guidance published on IAPT webpage</td>
</tr>
<tr>
<td>October 2019</td>
<td>Corrigendum published – minor changes Bi-annual SNOMED CT update</td>
</tr>
<tr>
<td>19/28 November 2019</td>
<td>National events</td>
</tr>
<tr>
<td>December 2019</td>
<td></td>
</tr>
<tr>
<td>January 2020</td>
<td></td>
</tr>
<tr>
<td>February 2020</td>
<td>Provider readiness questionnaire</td>
</tr>
<tr>
<td>March 2020</td>
<td></td>
</tr>
<tr>
<td>1 April 2020</td>
<td>Local data collection commences</td>
</tr>
<tr>
<td>1 May 2020</td>
<td>Data submissions commence</td>
</tr>
<tr>
<td>25 June 2020</td>
<td>Full conformance date – closure of April Refresh window</td>
</tr>
<tr>
<td>July 2020</td>
<td>First data extracts available</td>
</tr>
</tbody>
</table>
IAPT v2.0 – IAPT Data Set webpage

The updated Technical Output Specification, Data Model, System Conformance Checklist and SNOW documents, have been updated and published below that reflect these changes.

<table>
<thead>
<tr>
<th>Document</th>
<th>Current version</th>
<th>Last updated</th>
</tr>
</thead>
<tbody>
<tr>
<td>IAPT v2.0 Technical Output Specification</td>
<td>2.0.15</td>
<td>15 October 2019</td>
</tr>
<tr>
<td>IAPT v2.0 Data Model</td>
<td>2.0.15</td>
<td>18 October 2019</td>
</tr>
<tr>
<td>IAPT v2.0 User Guidance</td>
<td>1.0</td>
<td>5 September 2019</td>
</tr>
<tr>
<td>Mapping guidance from v1.5 to v2.0</td>
<td>1.0</td>
<td>4 September 2019</td>
</tr>
<tr>
<td>IAPT v2.0 SNOWED CT mapping</td>
<td>2.0</td>
<td>29 October 2019</td>
</tr>
<tr>
<td>IAPT v2.0 System Conformance Checklist</td>
<td>2.0.13</td>
<td>29 October 2019</td>
</tr>
</tbody>
</table>

Pilot data guidance

Version 2.0 now contains all of the necessary data requirements for the Employment Advisers and iHealth pilots collections, so these requirements will no longer be detailed in separate specifications.

How to submit data

This section will be updated in due course with information on making v2.0 submissions, including the submission platform and an extended submission window timetable covering the transition.

IAPT intermediate Database (IDB)

Before submission, your data must be entered into the latest version of the IDB.

For IAPT v2.0 submissions for April 2020 data onwards, the IDB will be made available to download.

• New look webpages
• Separate pages for v1.5, pilots and v2.0
• V2.0 webpage here
IAPT v2.0 – DCB1520 webpage

Current release

<table>
<thead>
<tr>
<th>Release date</th>
<th>05/09/2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Release number</td>
<td>Amd 14/2019</td>
</tr>
<tr>
<td>Release title</td>
<td>Version 2.0</td>
</tr>
<tr>
<td>Stage</td>
<td>Implementation</td>
</tr>
</tbody>
</table>

Key documents

- Requirements Specification (Amd 14/2019)
- Implementation Guidance (Amd 14/2019)
- Information Standards Notice (Amd 14/2019)
- Corrigendum (Amd 14/2019) (October 2019)
- Change Specification (Amd 14/2019) (October 2019)
- Data Set Specification (Amd 14/2019) (October 2019)

Supporting documents

- NHS Data Model and Dictionary Change Request - 1719 (Basic CR) (Amd 14/2019) (October 2019)
- NHS Data Model and Dictionary Change Request - 1719 (Data Set CR) (Amd 14/2019) (October 2019)

Further information

- NHS Digital IAPT web pages

Previous release

- IAPT v1.5 previously approved under the Information Standards Board (ISB)
- Documentation were available on the archived ISB webpage
- New DCB webpage for IAPT
- V2.0 and v1.5 formal standard documentation available together
- DCB webpage [here](#)
# IAPT v2.0 – Key documentation

<table>
<thead>
<tr>
<th>Document</th>
<th>Description</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requirement Specification</td>
<td>Timescales, scope, conformance (the “who” and “when”)</td>
<td>DCB1520 webpage</td>
</tr>
<tr>
<td>Implementation Guidance</td>
<td>Practical step-by-step guidance for implementing the data set as a new or existing user (the “how”)</td>
<td>DCB1520 webpage</td>
</tr>
<tr>
<td>Change Specification</td>
<td>Background context to the changes (the “why”)</td>
<td>DCB1520 webpage</td>
</tr>
<tr>
<td>Technical Output Specification</td>
<td>Design of each data group (the “what”) SNOMED codes for outcome measures</td>
<td>IAPT webpage</td>
</tr>
<tr>
<td>Data Model</td>
<td>Pictorial representation of the TOS</td>
<td>IAPT webpage</td>
</tr>
<tr>
<td>User Guidance</td>
<td>Additional guidance for data groups, FAQs, appendices for specific topics (e.g. interventions)</td>
<td>IAPT webpage</td>
</tr>
<tr>
<td>Terminology Mapping Guidance</td>
<td>Provides the SNOMED/ICD codes for submission of Therapy Types, LTC, MUS</td>
<td>IAPT webpage</td>
</tr>
<tr>
<td>Version 1.5 to 2.0 Gap Analysis</td>
<td>Where the v1.5 data flows in the new model</td>
<td>IAPT webpage</td>
</tr>
</tbody>
</table>

No ‘IAPT Technical Guidance’ – webpages will be updated to signpost to various existing SDCS resources
Recent Updates - Corrigendum

Published by the Data Coordination Board (DCB) on 31 October 2019

Minor amendments to the published IAPT Information Standard:

- A new data item INTEGRATED IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES LONG TERM CONDITION SERVICE INDICATOR in the IDS201CareContact table

- A change to the group-level notes for IDS004 Employment Status – clarify the 1:many relationship

- A change to the UID for Ex-British Armed Forces Indicator in the IDS001 Master Patient Index table

- A correction to a typo in the format for the data item DURATION OF INTERNET ENABLED THERAPY IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CARE PROFESSIONAL CLINICAL TIME

Mandatory field – should always be known

Appointment level – may move between LTC/Core during referral
Drivers for the proposal

1. Alignment between IAPT and MHSDS

2. Review of existing content to ensure the data set remains ‘minimum’

3. ‘New’ data requirements
Driver 1: Alignment with MHSDS data model

A full gap analysis has been undertaken between IAPT and MHSDS to identify the differences in data models and the impact of alignment.

Majority of alignment work agreed (via consultation) for v2.0:

• New Header table – improved submission metadata
• Aligning Appointment table with Care Contact/Activity model
• Using SNOMED to capture therapy types and outcome measures
• New Social and Personal Circumstances table to capture properties of the patient (e.g. Religion and Sexual Orientation) using SNOMED
• Pulling fields out of core tables into a ‘modular’ relational structure (e.g. moving Employment Status into a dedicated table)
## V1.5 versus V2.0: Gap Analysis

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - PERSON</td>
<td>NHS NUMBER</td>
<td>Exact match</td>
<td>IDS001MPI</td>
<td>NHS NUMBER</td>
</tr>
<tr>
<td>1 - PERSON</td>
<td>NHS NUMBER STATUS INDICATOR CODE</td>
<td>Exact match</td>
<td>IDS001MPI</td>
<td>NHS NUMBER STATUS INDICATOR CODE</td>
</tr>
<tr>
<td>1 - PERSON</td>
<td>LOCAL PATIENT IDENTIFIER (EXTENDED)</td>
<td>Exact match</td>
<td>IDS001MPI</td>
<td>LOCAL PATIENT IDENTIFIER (EXTENDED)</td>
</tr>
<tr>
<td>1 - PERSON</td>
<td>ORGANISATION CODE (CODE OF PROVIDER)</td>
<td>No Longer required</td>
<td></td>
<td>In IAPT v2.0 this item will no longer be required in the new Header table</td>
</tr>
<tr>
<td>1 - PERSON</td>
<td>PERSON BIRTH DATE</td>
<td>Exact match</td>
<td>IDS001MPI</td>
<td>PERSON BIRTH DATE</td>
</tr>
<tr>
<td>1 - PERSON</td>
<td>PERSON GENDER CODE CURRENT</td>
<td>Change in requirement</td>
<td>IDS001MPI</td>
<td>PERSON STATED GENDER CODE</td>
</tr>
<tr>
<td>1 - PERSON</td>
<td>POSTCODE OF USUAL ADDRESS</td>
<td>Exact match</td>
<td>IDS001MPI</td>
<td>POSTCODE OF USUAL ADDRESS</td>
</tr>
<tr>
<td>1 - PERSON</td>
<td>GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)</td>
<td>Exact match</td>
<td>IDS002GP</td>
<td>GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)</td>
</tr>
<tr>
<td>1 - PERSON</td>
<td>ETHNIC CATEGORY</td>
<td>Exact match</td>
<td>IDS001MPI</td>
<td>ETHNIC CATEGORY</td>
</tr>
<tr>
<td>1 - PERSON</td>
<td>RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE</td>
<td>Different format</td>
<td>IDS011SocPerCircumstances</td>
<td>SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT)</td>
</tr>
</tbody>
</table>
### Care Activities / Therapy Types

#### IDS202 Care Activity

<table>
<thead>
<tr>
<th>PK</th>
<th>Care Activity Identifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>FK1</td>
<td>Care Contact Identifier</td>
</tr>
<tr>
<td></td>
<td>Care Personnel Local Identifier</td>
</tr>
<tr>
<td></td>
<td>Clinical Contact Duration of Care Activity</td>
</tr>
<tr>
<td></td>
<td>Coded Procedure and Procedure Status (SNOMED CT)</td>
</tr>
<tr>
<td></td>
<td>Finding Scheme in Use</td>
</tr>
<tr>
<td></td>
<td>Coded Finding (Coded Clinical Entry)</td>
</tr>
<tr>
<td></td>
<td>Coded Observation (SNOMED CT)</td>
</tr>
<tr>
<td></td>
<td>Observation Value</td>
</tr>
<tr>
<td></td>
<td>UCUM Unit of Measurement</td>
</tr>
</tbody>
</table>

- ‘Procedure’ field = Therapy Type (1-4)
- Terminology Mapping document - old v1.5 therapies types mapped to SNOMED CT
- Changes to list also made for v2 – explained below mapping
Social and Personal Circumstances

To capture properties of the person

**Sexual Orientation** – alignment with new ‘fundamental’ standard

**Religious Affiliation** – Can now flow the ‘long’ list or the ‘short’ groups list, depending on what is captured locally (no need to map)

Both lists are SNOMED refsets linked within the NHS Data Model & Dictionary

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### Appendix A: SNOMED CT mapping

<table>
<thead>
<tr>
<th>SNOMED CT ID</th>
<th>Fully Specified Name</th>
<th>Synonym</th>
<th>DD ID</th>
<th>Data Dictionary</th>
<th>READ2 ID</th>
<th>Term Code</th>
<th>Read2 Term Code</th>
<th>CTV3 ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>20430005</td>
<td>Heterosexual (finding)</td>
<td>Straight</td>
<td>1</td>
<td>Heterosexual or straight</td>
<td>1b160</td>
<td>0</td>
<td>Heterosexual</td>
<td>X766q</td>
</tr>
<tr>
<td>89217008</td>
<td>Female Homosexual (finding)</td>
<td>Lesbian</td>
<td>2</td>
<td>Gay or Lesbian</td>
<td>1b200</td>
<td>0</td>
<td>Lesbian</td>
<td>E2201</td>
</tr>
<tr>
<td>76102007</td>
<td>Male Homosexual (finding)</td>
<td>Gay</td>
<td>2</td>
<td>Gay or Lesbian</td>
<td>1b210</td>
<td>0</td>
<td>Male homosexuality</td>
<td>E2200</td>
</tr>
<tr>
<td>42035005</td>
<td>Bisexual (finding)</td>
<td>3</td>
<td>Biomedical</td>
<td>Bisexual</td>
<td>1b000</td>
<td>0</td>
<td>Bisexual</td>
<td>X666r</td>
</tr>
<tr>
<td>472985009</td>
<td>Sexually attracted to neither gender (finding)</td>
<td>4</td>
<td>Other sex orientation not listed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>440583007</td>
<td>Sexual Orientation unknown (finding)</td>
<td>9</td>
<td>Not known (not recorded)</td>
<td>1b300</td>
<td>0</td>
<td>Sexual orientation unknown</td>
<td>XaPO:</td>
<td></td>
</tr>
<tr>
<td>1064711000000108</td>
<td>Sexual Orientation undecided (finding)</td>
<td>U</td>
<td>PERSON asked and does not or is not sure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>729951000000104</td>
<td>Sexual orientation not given- patient refused (finding)</td>
<td>Z</td>
<td>Not stated (PERSON asked but declined)</td>
<td>1b400</td>
<td>0</td>
<td>Sexual orientation not given</td>
<td>XaWS</td>
<td></td>
</tr>
</tbody>
</table>

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The **RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION** group of a PERSON, as specified by a PERSON.

Note: This is the **Religious Affiliation** of a PERSON, not their Religion.

**RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE** is aligned with descriptors for “Religious or other belief system & National Codes:

A: Bahai
B: Buddhist
C: Christian
Routine Outcome Measures

Changes to model
All outcome measures will now flow as a SNOMED code in one of two locations:
IDS606: Linked to referral rather than appointment (e.g. PEQs, ROMs captured digitally…)
IDS607: Linked to appointment (large majority of ROMs should still link to appointment as per v1.5)

Changes to measures
• 2 new measures – Body Image Questionnaire (for body dysmorphic disorder) and Productivity Cost Questionnaire (iPCQ)
• Most LTC/MUS pilot measures migrated into main data set (IBS-SSS and CFQ outstanding)
• PCL-5 to replace Impacts of Events Scare (IES) Revised
• Removal of Agoraphobia Score, Social Phobia Score, Specific Phobia Score

IMPORTANT
Please see the National Clinical Content Repository (NCCR) – Clinical Licensing Service webpage:
https://digital.nhs.uk/services/national-clinical-content-repository-copyright-licensing-service
Organisations can register to the service and now access sub-licenses for existing and new IAPT measures
Routine Outcome Measures

SNOMED CT mappings are provided in the ‘ROM Mapping’ tab within the Technical Output Specification.

This reference table is used to validate the content submitting in IDS606/IDS607.

Note: The SNOMED CT concept is always the ‘observable entity’ – i.e. the question being asked.

---

<table>
<thead>
<tr>
<th>Assessment Tool Name</th>
<th>Preferred Term (SNOMED-CT)</th>
<th>Active Concept ID (SNOMED-CT)</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body Image Questionnaire (BIQ)</td>
<td>BIQ (Body Image Questionnaire) score</td>
<td>TBC</td>
<td>0-72</td>
</tr>
<tr>
<td>Brief Pain Inventory (BPI)</td>
<td>Brief pain inventory score</td>
<td>443223006</td>
<td>0.70</td>
</tr>
<tr>
<td>COPD Assessment Test (CAT)</td>
<td>Chronic obstructive pulmonary disease assessment test score</td>
<td>445660005</td>
<td>0.40</td>
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<tr>
<td>Diabetes Distress Scale (DDS)</td>
<td>Diabetes Distress Scale 17 item score</td>
<td>9109310000000101</td>
<td>17.102</td>
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<tr>
<td>Generalised Anxiety Disorder 7 (GAD-7)</td>
<td>Generalised anxiety disorder 7 item score</td>
<td>445456005</td>
<td>0.21</td>
</tr>
<tr>
<td>Health Anxiety Inventory (HAI) - Week</td>
<td>Health anxiety inventory short week score</td>
<td>446793008</td>
<td>0.54</td>
</tr>
<tr>
<td>HADS - Depression/Anxiety Scale</td>
<td>HADS Depression and Anxiety Scale</td>
<td>502</td>
<td>3.40</td>
</tr>
</tbody>
</table>

*Please note that this table will be updated with guidance on a continual basis, this will not impact on the content but will help with general submission issues or deriving total scores where required.*
## Presenting Complaints

### IDS101 Service or Team Referral

<table>
<thead>
<tr>
<th>PK</th>
<th>Service Request Identifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>FK1</td>
<td>Local Patient Identifier (Extended)</td>
</tr>
<tr>
<td>FK1</td>
<td>Organisation Identifier (Code of Commissioner)</td>
</tr>
<tr>
<td>FK1</td>
<td>Referral Request Received Date</td>
</tr>
<tr>
<td>FK1</td>
<td>Source of Referral for Mental Health</td>
</tr>
<tr>
<td>FK1</td>
<td>Year and Month of Symptoms Onset (IAPT)</td>
</tr>
<tr>
<td>FK1</td>
<td>Previous Diagnosed Condition Indicator</td>
</tr>
<tr>
<td>FK1</td>
<td>Discharge From IAPT Service Reason</td>
</tr>
<tr>
<td>FK1</td>
<td>Service Discharge Date</td>
</tr>
</tbody>
</table>

### IDS603 Presenting Complaints

<table>
<thead>
<tr>
<th>FK1</th>
<th>Service Request Identifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>FK1</td>
<td>Finding Scheme in Use</td>
</tr>
<tr>
<td>FK1</td>
<td>Presenting Complaint (Coded Clinical Entry)</td>
</tr>
<tr>
<td>FK1</td>
<td>Presenting Complaint Coding Significance</td>
</tr>
<tr>
<td>FK1</td>
<td>Presenting Complaint Recorded Date</td>
</tr>
</tbody>
</table>

### What’s in the name?

Replaces the PROVISIONAL DIAGNOSIS data item from REFERRAL table.

Old item was also known as ‘Problem Descriptor’.

New name is to align closer with the definition/purpose and for consistency across data sets going forward.

Locally can still refer to ‘Problem Descriptor’.

### Populating the table

Finding Scheme in Use = ICD10 or SNOMED CT

Presenting Complaint =

A) Usual anxiety/depression F codes in ICD10 (no change!)

+ B) MUS (IBS, CFS, Somatic Symptom Disorder)

Coding Significance = Primary/Secondary, allow additional secondary problems to be reported

Recorded Date – When was this identified?
Recent Updates – SNOMED CT Mappings

Terminology Mapping Guidance republished 29 October:

- Addition of the ‘new’ SNOMED concepts authored in the October SNOMED update (these were previously marked ‘TBC’)
- Replace references to ‘medically unexplained symptoms’

One outstanding code exists:

- Mapping for ‘MUS – Other’ has been removed and a new concept of ‘Somatic Symptom Disorder’ will be authored in April 2020 SNOMED CT release (Not ICD10)
**Driver 2: Review of existing content**

Following consultation, the following fields have been agreed for **deletion**:

From v1.5:
- **LONG TERM PHYSICAL HEALTH CONDITION INDICATOR** – Replaced by a more detailed collection
- **CARE PROFESSIONAL ROLE CODE** – replaced with qualifications table
- **OPT IN DATE** – Opt in model no longer supported nationally
- **STEPPED CARE INTENSITY DELIVERED** – to be derived centrally
- **SERVICE REQUEST ACCEPTANCE INDICATOR** – not required for analysis
- Various duplicate linkage fields (e.g. NHSNO no longer required in every table)

From EA Pilot:
- Employment Support Type
- Last EA Appointment Indicator

From LTC/MUS Pilot:
- Client Service Receipt Inventory (CSRI)

**Key Point:** These fields may still be collected locally, if useful. They are just not required for national secondary uses.
Driver 3: New data requirements

**IAPT-specific ‘new’ requirements:**

- New set of referral end codes
- Amended Therapy Types list
- Updates to Routine Outcome Measures
- Reflect internet enabled therapies
- Language/interpreter needs
- Qualifications of care personnel
- Size of group sessions (# participants vs facilitators)
- Location types and associated site codes
- New employment/education requirements (self-employed and university students)

**Mop-up from v1.5**

- Incorporation of EA pilot fields
- Incorporation of LTC/MUS pilot fields
- Clarify scope to include u18s accessing adult services

**Wider requirements:**

- Overseas Visitor Charging Category
- Alignment with new ODS standard
- Alignment of gender and sexual orientation fields with latest versions
Use cases for terminology

A number of policy reporting requirements to be met via terminology

Requires collaborative guidance covering end-to-end data flow:
1. Capturing and using data locally = policy/clinical guidance
2. Flowing this data nationally = data set guidance

Future topics of interest may include:
• Peri/post natal period findings – covered in afternoon session
• Asylum Status
• Contextual factors (alcohol/drug use, smoking, gambling, debt)
• Homelessness (and risk of)
Use cases for terminology

User Guidance - Appendix 3 Care Activity Guidance

• Illustration of how the data items work together
• List of required uses

Specific National Reporting Requirements

Smoking Status
Patient smoking status should be submitted as part of the data set in line with local clinical practice for collecting this information.

NHS Digital have provided mapping to the consistent list used in MHSDS and other data sets, which MAY be used by IAPT services. However, where greater granularity is already recorded, providers can submit that data and it will be aggregated to the higher level during analysis. E.g. if ‘Ex-very heavy cigarette smoker (40+ /day)’ is submitted it would appear in analysis as ‘ex-smoker’.

<table>
<thead>
<tr>
<th>SNOMED CT Concept</th>
<th>SNOMED CT Concept ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>smoker (finding)</td>
<td>77176002</td>
</tr>
<tr>
<td>ex-smoker (finding)</td>
<td>8517006</td>
</tr>
<tr>
<td>current non smoker but past</td>
<td>405746006</td>
</tr>
<tr>
<td>smoking history unknown (finding)</td>
<td>266919005</td>
</tr>
</tbody>
</table>

Asylum Status
Consent model – New guidance #1

IAPT v1.5 is deemed a consented collection due to inconsistencies across various guidance materials.

It is likely providers have mixed approaches due to local interpretation of guidance.

Action?
To confirm the data set as a legally obligated return by addressing inconsistencies.

Why?
Complete set of data for aggregate national reports (true picture) + patient consent to be managed via national data opt out
Consent model – New guidance continued…

How? To be achieved by:

1. Issuing a Data Provision Notice (DPN) – due early 2020
2. Aligning guidance to this position, such as by addressing the Implementation Guidance
3. Issuing additional consent guidance to support services with the change – simplifying the transition for those impacted (apply to new referrals after 1 April)

Implementation Guidance:

<table>
<thead>
<tr>
<th>IAPT v1.5</th>
<th>IAPT v2.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Explicit consent is not required; however, providers are encouraged to seek consent from patients for their information to be used to support secondary uses wherever possible and in line with local policy.”</td>
<td>“explicit consent to flow data from provider to NHS Digital is not required; however, providers are required to inform patients that their information will be used to support secondary uses and should highlight the national data opt-out process as part of their transparency information.”</td>
</tr>
</tbody>
</table>
Validations

New data model + new validation engine = some differences in the way the data is validated

102 unique messages in v1.5 Vs ~350 unique messages in v2.0

Not necessarily more stringent, but more granular messages to identify the specific DQ issue:
• E.g. All code lists have a warning for invalid values

A few differences in mandation. E.g. Null GP/Commissioner fields now rejection rather than warning
Validations

Submission format: Combined Primary and Refresh submission no longer supported?

Inclusion Rules
v1.5 – Data outside of the reporting period is ‘ignored’
v2.0 – Data outside of the reporting period is ‘rejected’ with a message

If a large amount of data is submitted, outside of the required range, then numerous rejection messages will be generated. This may hinder the ability to identify 'real' rejection messages that require corrections to be made to “included” data.

Currently assessing treatment of ‘End Dates’ across data sets. Future ‘End Dates’ currently rejected but may be ‘ignored’ to reduce burden of data cleansing live data
Other technical aspects

**IDB**
Will be published via TRUD as soon as possible

**Master Patient Service**
Migration of patient-matching logic to central MPS – consistency across NHS Digital data sets
May lead to an increase/decrease in overall patient numbers – impact assessment to be undertaken

**Derivations**
- Not yet published
- Aim to provide ‘added value’ with the processing of the data
- Address known issues with v1.5 derivations

**Diagnostics**
- Also not yet published
- Existing diagnostics under review + consideration for new diagnostics
- Provide improved insight into future reporting at the ‘pre-deadline’ stage
Implementation Support and Engagement

• State of Readiness Questionnaire – February 2019

• Webinars to be planned throughout the new year – what would benefit? Please provide thoughts on the feedback form.

• Sign up to the Mental Health Newsletter Distribution via online form https://crm.digital.nhs.uk/clickdimensions/?clickpage=/jxgkfjleeeebfnaqb6vdwq

• Get in touch: enquiries@nhsdigital.nhs.net subject heading ‘IAPT V2.0’
Data Processing Services (DPS) update
Introducing SDCS Cloud
Our improved Data Processing Services (DPS)

We are developing our Data Processing Services to transform how we collect, process and use data to improve health and care.

- Faster data processing
- Better data quality
- Protect patient data
- Better data linkage
- Improved data access
## Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Data Collection Service (SDCS)</strong></td>
<td>Web application supporting secure submissions for national data collections</td>
</tr>
<tr>
<td><strong>Master Person Service (MPS)</strong></td>
<td>Person tracing system that uses the Personal Demographic Service and enhanced matching algorithms</td>
</tr>
<tr>
<td><strong>De-ID</strong></td>
<td>Nationally consistent de-identification (De-ID) tool</td>
</tr>
<tr>
<td><strong>Core Platform</strong></td>
<td>Framework that integrates components, processing and storage</td>
</tr>
<tr>
<td><strong>Data Access Environment (DAE)</strong></td>
<td>A secure way for users to remotely access better linked information faster</td>
</tr>
</tbody>
</table>
Our Data Processing Services

DPS Core

Collect

SDCS cloud

Submit

Monitor

Data Management

Process

Landing and Staging

Data Quality

MPS

Business Rules

De-ID

Access

Data Linkage Preparation

DAE

DARS Online

Access

Provider
“SDCS cloud (Strategic Data Collection Service in the cloud) is the way to submit IAPT data to NHS Digital’s new Data Processing Services (DPS).”
SDCS Cloud benefits…

**Internet-facing**
Does not require N3 or HSCN connection, making it easier for more providers to submit data.

**Two-factor authentication**
Secure method of confirming user identity

**Faster Processing and Data Quality feedback**
Data and DQ feedback available in hours rather than days

**Secure solution**
Using cloud technology of the future

**Improved user experience**
Completely new tool designed with users in mind
Coverage of Mental Health Services Dataset has consistently increased over the last two years, with significant interventions including establishment of NHS Digital MH Data Quality Team and the move to the SDCS Cloud.
Data standard versions

Migration to SDCS Cloud will coincide with the move to the **IAPT v2.0** information standard.

- **IAPT v1.5** data, up to and including the **March 2020** reporting period, should be submitted using the Bureau Service Portal (BSP).
- **IAPT v2.0** data from **April 2020** reporting period must be submitted using SDCS Cloud.

![Diagram showing migration process from Current (BSP) to Future (DPS) with SDCS Cloud and DPS Core as intermediate steps]
High-level timeline

We worked closely with providers to develop the new tool to meet their needs. We’ll be reaching out to do the same with IAPT submitters over the coming months.

- **Development and delivery** - Early 2020
- **User engagement** - January > Go live
- **User Registration** for SDCS Cloud - Early 2020
- **SDCS Cloud available** to submit new data standard – from May 2020
Lessons learned from Mental Health and Maternity migration

We have already moved the **Mental Health** and **Maternity Services** data sets onto SDCS Cloud in May 2019.

- Go-live issues – we will address these for IAPT through:
  - Earlier registration of users
  - Testing of submissions with provider pilot
  - Closer engagement with users during development (webinars etc.)
What happens next?

We will:

• provide **regular email updates** between now and transition.
• Identify providers for **pilot testing**
• Invite users to **Show and Tell webinars** in the months running up to migration to show how to register and submit data.

If you have any questions about SDCS Cloud, please contact the NHS Digital email centre at **enquiries@nhsdigital.gov.uk**
IAPT Provider Support

Ian Binns
Head of Information
NHS Digital
28th November 2019
IAPT Provider Support

• Who am I?
  • Transformation: Product / Delivery split
  • Head of Product for Local and Regional Organisations

• Who are you?
  • Providers
  • Commissioners
  • Commissioning Support
  • ALBs
  • System Suppliers
  • Clinical Networks
  • Others
IAPT Submissions

- IAPT v2 in effect from 1\textsuperscript{st} April 2020
- Submissions will be via SDCS Cloud

- More Questions ...
  - How many IAPT Providers also provide mental health services?
  - How many have submitted the mental health dataset?
  - How many have registered to submit to SDCS Cloud?
IAPT Submissions

• SDCS Cloud is now live and collecting mental health and maternity datasets.
• SDCS Cloud is internet facing.
• SDCS Cloud is more secure – and requires 2 Factor Authentication.

• More Questions ...
  • How many IAPT providers have used 2 factor authentication?
IAPT Preparation ...

- Registration for SDCS
  - Investigating automated registration for BSP Exeter users
  - If you haven’t used BSP Exeter for a while ...
  - May require manual registration (eg new submitters)

- SDCS Cloud Log on
  - 2 factor Authentication
  - Ensure 2 users log on to SDCS Cloud

- Submissions
  - Test file
  - Pilots
IAPT Preparation ...

• We will monitor ...
  • How many providers submit IAPT v1.5 to BSP Exeter
  • How many have successfully registered for SDCS Cloud
  • How many have successfully logged on
  • How many have successfully submitted a test file
IAPT Preparation and Support ...

• How else can providers prepare ...
  • Submit your data as soon as the window opens ...
  • Access the data quality reports for your submission ...

• What is the best way that we can support you ...?
  • Regular newsletters?
  • Webinars?
  • More frequent events?
  • 1-1 contact?
  • A named contact?
  • IAPT User Group?
Overview

This national data set has been collected since April 2012 and is a mandatory submission for all NHS funded care, including care delivered by independent sector healthcare providers. This feeds into monthly, quarterly and annual reporting of key measures. These are used by:

- National bodies, e.g. NHS England
- Commissioners
- Journalists
- Researchers and academics
- The public
Reporting format

Publications typically have:

- Executive summary
- Data quality report
- Power BI dashboard
- Metadata
- CSV file
- Separate reporting for EA and IC pilots

Disclosure control: Rounding and suppression applied to small numbers

**IAPT guidance** - helpful document for a wide range of users to help understand and interpret published IAPT data

[www.digital.nhs.uk/iapt](http://www.digital.nhs.uk/iapt)
Key measures and targets

• **Activity**
  - Referrals received
  - Entered treatment
  - Finished treatment

• **Waiting times to first treatment**
  - <6 weeks - 75% of referrals seen within 6 weeks target **87.3%**
  - <18 weeks - **95% seen within 18 weeks target 98.8%**

• **Outcomes**
  - Recovery - **50% recovery rate target 52.2%**
  - Reliable recovery
  - Reliable improvement
Data quality

• Coverage – need all 160+ providers that submit data to BSP to be able to submit to SDCS cloud

• Completeness – need all data reported in the appointments table to be reported in the activity tables (purple boxes) of the new data model using SNOMED

It is very important for analysis and reporting to continue after DPS and V2.0 migration for the IAPT programme
How are data used by NHS Digital?

Once received, NHS Digital carry out the following activities:

• **Validation**: these are rules applied to the data to ensure it is of sufficient quality. For example, certain data items cannot be missing (like the referral’s unique ID, or an appointment’s date) otherwise the data would not be useable.

• **Pseudonymisation**: to ensure the protection of patients’ confidentiality, analysts at NHS Digital cannot see data items that would identify an individual (such as date of birth or NHS number). These data are replaced with ‘pseudo-identifiers’, which are numbers that allow analysts to identify a record consistently without knowing personal information.

• **Linkage**: As NHS Digital receive only a month of data at a time, for us to know information about the whole referral pathway it is necessary to link new data to previous months’ submissions so that we can identify appointments that occurred in the past that are related to a current referral.
Reporting after migration

• Existing reporting and measures (priority)
• Submission of SNOMED data is key for:
  • therapy types (Table IDS202)
  • patient experience questionnaires (Table IDS606)
  • routine outcome measures (Table IDS607)
• Use the SNOMED mappings provided in the TOS and guidance
• Include new measures, e.g. internet enabled therapies
• Review publication outputs and formats
How you can help

• Check which data items you should submit
• Check the quality of your submission
• Use all the support and resources available
• Use the Data Model, Technical Output Specification and Metadata together to understand what services are being measured against and what data you need to submit to ensure accurate reporting
QUESTIONS?

Connect with us

@nhsdigital
company/nhs-digital
www.digital.nhs.uk

Information and technology for better health and care
POLICY UPDATE
**Five Year Forward View**

**Access**

By Q4 2018/19, 19% of people with anxiety &/or depression were receiving treatment

- Waiting time standards are consistently exceeded
- Expansion of employment support advisers

**Recovery**

Recovery rate standard of 50% has been exceeded for past 2+ years

**Pathway**

Implementation of IAPT-LTC

**What comes next?**

Continue to deliver the remainder of the FYFV commitments; expand access to 1.5m per year, maintain performance against standards, roll out IAPT-LTC

Increase access to services even further under the LTP plans; to 1.9m people by 2023/24

Expanding the workforce is critical for delivery of these ambitions

www.england.nhs.uk
Long-term plan commitments for IAPT

Overarching ambition:
We will continue expand access to IAPT services for adults and older adults with common mental health problems, with a focus on those with long-term conditions

By 2023/24, an additional 380,000 adults and older adults will be able to access IAPT services; taking the total to 1.9m per year

- All areas are expected to maintain the existing IAPT standards for referral to treatment waiting times and recovery.
- The existing requirement to commission IAPT-LTC remains a priority
- All areas expected to plan to meet the needs of their local populations to address inequalities e.g.
  - Improving access for older people
  - Improving access and outcomes for:
    - younger people
    - BAME etc
### IAPT LTP commitments, year by year

#### Planning and delivery requirements:

<table>
<thead>
<tr>
<th>Ambition</th>
<th>2019/20</th>
<th>2020/21</th>
<th>2021/22</th>
<th>2022/23</th>
<th>2023/24</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IAPT Access (All ages)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A total of 1.3m adults and older adults accessing treatment [FYFVMH commitment]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A total of 1.5m adults and older adults accessing treatment [FYFVMH commitment]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A total of 1.6m adults and older adults accessing treatment [An additional 129,000 accessing treatment above FYFVMH ambitions]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A total of 1.8m adults and older adults accessing treatment [An additional 258,000 accessing treatment above FYFVMH ambitions]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A total of 1.9m adults and older adults accessing treatment [An additional 380,000 accessing treatment above FYFVMH ambitions]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IAPT Referral to Treatment Time and Recovery Standards</strong></td>
<td>IAPT Referral to Treatment Time and Recovery Standards maintained</td>
<td>IAPT Referral to Treatment Time and Recovery Standards maintained</td>
<td>IAPT Referral to Treatment Time and Recovery Standards maintained</td>
<td>IAPT Referral to Treatment Time and Recovery Standards maintained</td>
<td>IAPT Referral to Treatment Time and Recovery Standards maintained</td>
</tr>
<tr>
<td><strong>IAPT Long Term Conditions (IAPT-LTC)</strong></td>
<td>All areas have IAPT-LTC service in place</td>
<td>All areas have IAPT-LTC service in place</td>
<td>All areas have IAPT-LTC service in place</td>
<td>All areas have IAPT-LTC service in place</td>
<td>All areas have IAPT-LTC service in place</td>
</tr>
</tbody>
</table>

- FYFV period used APMS prevalence estimates from 2000
- LTP period uses APMS prevalence estimates from 2014
  - Higher due to population growth & inclusion of over 75s
  - CCGs should have already been accounting for this via annual planning process
Integrating IAPT services for long term conditions
IAPT-LTC Integration

- Two thirds of people with a long term physical health condition also have a co-morbid mental health problem, mostly anxiety and depression.

- These common mental health disorders are detectable and treatable.

- As set out in Implementing the Five Year Forward View for Mental Health the expansion of IAPT services should focus on people with LTCs.

- New psychological therapy provision has seen physical and mental health care provision co-located.

- Therapy is integrated into existing medical pathways and services – either primary care, or secondary care services (e.g. diabetes, cardiac, respiratory).

- NICE-recommended therapies, adapted for people with long term conditions and delivered by properly trained therapists. **Hence the need for CPD courses for IAPT HI therapists & PWPs**
Which Long Term Conditions?

The most common LTCs that have been seen in new integrated IAPT services:-

- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- Cardiovascular disease (CHD)
- Musculoskeletal problems, Chronic pain.

Colocation for the Early Implementers:-

- GP Practices/Primary Care
- Acute Hospitals and Secondary Care
- Community Teams
IAPT-LTC Integration

- Access to evidence based psychological therapies for people with LTC or MUS by in IAPT-LTC services are defined by:

  Care genuinely integrated into physical health pathways in primary, community or acute care, working as part of a multidisciplinary team

  Evidence based treatments provided by IAPT practitioners who are co-located with physical healthcare colleagues

  Treatment is delivered by IAPT staff who have attended the IAPT-LTC/MUS top up training
New Data Item – Integrated LTC?

Is the appointment part of the:

• integrated-LTC service
• core IAPT service

It is possible for a patient to have an LTC but the appointment is core IAPT and not part of the integrated service.

*We need to distinguish*
Outcomes from Early Implementer Sites

- 50% recovery rate achieved for patients in the LTC cohort in most sites
- Reductions of primary care appointment utilisation demonstrated universally
- Reductions shown across the wider system – particularly in reported days off sick
- Variation in where return on investment can be achieved between pathways
- Where increases in utilisation have occurred this is recognised as being a positive demonstration of condition management
The IAPT-LTC service started October 2016 and saw 1,017 patients (to end Sept 2017).

Results point to a reduction in healthcare utilisation in other parts of the healthcare system before and after intervention for different care pathways.

The initial evaluation indicates savings overall of £854,253.

Reduced pressure across the health system

Data: Cambridgeshire and Peterborough CCG
Reductions across pathways

- An expected saving of £693.69 per patient has been demonstrated across both Primary and Acute care for those accessing IAPT-LTC

- For the full cohort of 1,363 patients who accessed the service in its first year, this scales up to cost savings of £408.9k at lowest estimate (no reduction in secondary health usage) and £1,482,099 at the 20% estimate for health care usage reductions across the system

Data: Dorset CCG
Older People

- We are seeing more older adults accessing IAPT-LTC services compared to core IAPT.
- This may be because more older people are likely to have long term physical health conditions.
- This could also be the result of a more holistic integrated offer reducing the stigma around accessing mental health support.

Data: Time to Talk Health Sussex Community FT
Specific Long Term Conditions can now be recorded:

<table>
<thead>
<tr>
<th>National Code</th>
<th>National Code Definition</th>
<th>SNOMED CT Concept ID</th>
<th>SNOMED CT Concept Preferred Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Diabetes</td>
<td>73211009</td>
<td>Diabetes mellitus (disorder)</td>
</tr>
<tr>
<td>11</td>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>13645005</td>
<td>Chronic obstructive lung disease (disorder)</td>
</tr>
<tr>
<td>12</td>
<td>Asthma</td>
<td>195967001</td>
<td>Asthma (disorder)</td>
</tr>
<tr>
<td>13</td>
<td>Other Respiratory Disease</td>
<td>50043002</td>
<td>Disorder of respiratory system</td>
</tr>
<tr>
<td>14</td>
<td>Heart disease</td>
<td>56265001</td>
<td>Heart disease (disorder)</td>
</tr>
<tr>
<td>15</td>
<td>Cancer</td>
<td>363346000</td>
<td>Malignant neoplastic disease (disorder)</td>
</tr>
<tr>
<td>16</td>
<td>Musculoskeletal Disorder (MSK)</td>
<td>328000</td>
<td>Disorder of musculoskeletal system (disorder)</td>
</tr>
<tr>
<td>17</td>
<td>Chronic pain, including fibromyalgia</td>
<td>373673007</td>
<td>Disorder characterized by pain</td>
</tr>
<tr>
<td>18</td>
<td>Epilepsy</td>
<td>34757009</td>
<td>Epilepsy (disorder)</td>
</tr>
<tr>
<td>19</td>
<td>Skin condition including Eczema</td>
<td>395320005</td>
<td>Disorder of skin (disorder)</td>
</tr>
<tr>
<td>20</td>
<td>Digestive tract conditions</td>
<td>393619000</td>
<td>Disorder of digestive system (disorder)</td>
</tr>
<tr>
<td>96</td>
<td>Other</td>
<td>Service to submit relevant SNOMED CT concept for the condition</td>
<td></td>
</tr>
<tr>
<td>97</td>
<td>None</td>
<td>7480310000000103</td>
<td>No history of long term condition</td>
</tr>
<tr>
<td>98</td>
<td>Unknown</td>
<td></td>
<td>No longer required for national submission</td>
</tr>
<tr>
<td>99</td>
<td>Not Stated</td>
<td></td>
<td>No longer required for national submission</td>
</tr>
</tbody>
</table>
MUS items will now be recorded using ICD-10 codes:

<table>
<thead>
<tr>
<th>Data Group</th>
<th>Data item</th>
<th>ICD-10 Code</th>
<th>ICD-10 Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Irritable Bowel Syndrome</td>
<td>K58</td>
<td>Irritable bowel syndrome</td>
</tr>
<tr>
<td>11</td>
<td>Chronic Fatigue Syndromes/ Myalgic Encephalopathy (ME)</td>
<td>G93.3</td>
<td>Postviral fatigue syndrome</td>
</tr>
<tr>
<td>12</td>
<td>MUS – not otherwise specified</td>
<td>F45.9</td>
<td>Somatoform disorder, unspecified</td>
</tr>
</tbody>
</table>

We will work with IT suppliers to change terminology from MUS to....

……..Persistent Physical Symptoms
Outcome Measures
Licence Agreements - Agreed

Body Image Questionnaire (BIQ)
Brief Pain Inventory (BPI)
COPD Assessment Test (CAT)
Diabetes Distress Scale (DDS)
Generalised Anxiety Disorder 7 (GAD-7)
Health Anxiety Inventory (HAI) – Week
IAPT Treatment Patient Experience Questionnaire
IAPT Assessment Patient Experience Questionnaire
Francis IBS Scale (IBS-SSS)
iMTA Productivity Cost Questionnaire (iPCQ)
Mobility Inventory (MI) for Agoraphobia
Obsessive Compulsive Inventory (OCI)
Panic Disorder Severity Scale (PDSS)
Patient Health Questionnaire-9 (PHQ-9)
Patient Health Questionnaire-15 (PHQ-15)
Penn State Worry Questionnaire (PSWQ)
Work And Social Adjustment Scale

https://digital.nhs.uk/services/national-clinical-content-repository-copyright-licensing-service

www.england.nhs.uk
Licence Agreements – Yet to be Agreed

Chalder Fatigue Scale (CFQ 11)
Licence Agreements – Refused

Impacts of Events Scale (IES)

Post Traumatic Stress Disorder (PTSD) Checklist for DSM-5 - (PCL-5)
The qualification or individual accreditation attained or planned to be attained, by the Care Personnel.

<table>
<thead>
<tr>
<th>National Code</th>
<th>Improving Access to Psychological Therapies Care Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Curriculum for Psychological Wellbeing Practitioners (PWP)</td>
</tr>
<tr>
<td>11</td>
<td>Curriculum for High-Intensity Cognitive Behavioural Therapy (CBT)</td>
</tr>
<tr>
<td>12</td>
<td>Curriculum for Counselling for Depression (CID)</td>
</tr>
<tr>
<td>13</td>
<td>Curriculum for Couple Therapy for Depression (CTfD) / Curriculum for Behavioural Couples Therapy (BCT) for Depression</td>
</tr>
<tr>
<td>14</td>
<td>Curriculum for Dynamic Interpersonal Therapy (DIT) for Depression</td>
</tr>
<tr>
<td>15</td>
<td>Curriculum for Practitioner Training in Interpersonal Psychotherapy (IPT)</td>
</tr>
<tr>
<td>16</td>
<td>Curriculum for Mindfulness-based Cognitive Therapy (MBCT)</td>
</tr>
<tr>
<td>17</td>
<td>Curriculum for Eye Movement Desensitisation Reprocessing (EMDR)</td>
</tr>
<tr>
<td></td>
<td>Improving Access to Psychological Therapies Employment Advisers</td>
</tr>
<tr>
<td>30</td>
<td>Curriculum for Employment Advisers</td>
</tr>
<tr>
<td>31</td>
<td>Curriculum for Senior Employment Advisers</td>
</tr>
</tbody>
</table>

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Care Professional Qualifications

- Primary role in IAPT field has been removed.

- New field should auto-populate data set for each staff members appointment

- Clinical leads should ensure all entries in staff table correspond to an individual’s known qualifications.

- Likely to reduce missing workforce data

- Analysis of key outcome metrics by qualification
Group size / Facilitators
Group Size / Facilitators

NUMBER OF GROUP THERAPY PARTICIPANTS

NUMBER OF GROUP THERAPY FACILITATORS

Derived: Ratio of therapists per patient attending

www.england.nhs.uk
Language & Interpreter
# Language & Interpreters

<table>
<thead>
<tr>
<th>LANGUAGE CODE (PREFERRED)</th>
<th>All Spoken Languages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Extensions</td>
<td></td>
</tr>
<tr>
<td>Braille (for people who are unable to see)</td>
<td></td>
</tr>
<tr>
<td>American Sign Language</td>
<td></td>
</tr>
<tr>
<td>Australian Sign Language</td>
<td></td>
</tr>
<tr>
<td>British Sign Language</td>
<td></td>
</tr>
<tr>
<td>Makaton (devised for children and adults with a variety of communication and Learning Disabilities)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>LANGUAGE CODE (OF TREATMENT)</th>
<th>All Spoken Languages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Extensions</td>
<td></td>
</tr>
<tr>
<td>Braille (for people who are unable to see)</td>
<td></td>
</tr>
<tr>
<td>American Sign Language</td>
<td></td>
</tr>
<tr>
<td>Australian Sign Language</td>
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<tr>
<td>British Sign Language</td>
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<tr>
<td>Makaton (devised for children and adults with a variety of communication and Learning Disabilities)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>USE OF INTERPRETER INDICATION CODE</th>
<th>Yes - Professional interpreter</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes - Family or friend</td>
</tr>
<tr>
<td></td>
<td>Yes - Other</td>
</tr>
<tr>
<td></td>
<td>No - Interpreter not required</td>
</tr>
<tr>
<td></td>
<td>No - Interpreter was required but did not attend</td>
</tr>
<tr>
<td></td>
<td>Not Known (Not Recorded)</td>
</tr>
</tbody>
</table>
End Codes
The Problem

• IAPT metrics are complex and can be easily misunderstood.

Referrals received: 1,603,649
Entering treatment: 1,092,296
Finished treatment: 582,556

IAPT fails a million people a year
IAPT’s true recovery rate is 25%, not the 50% that NHS England claims
### Referral End Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Referred but not seen</td>
</tr>
<tr>
<td>50</td>
<td>Not assessed</td>
</tr>
<tr>
<td>10</td>
<td>Not suitable for IAPT service - no action taken or directed back to referrer</td>
</tr>
<tr>
<td>11</td>
<td>Not suitable for IAPT service - signposted elsewhere with mutual agreement of patient</td>
</tr>
<tr>
<td>12</td>
<td>Discharged by mutual agreement following advice and support</td>
</tr>
<tr>
<td>13</td>
<td>Referred to another therapy service by mutual agreement</td>
</tr>
<tr>
<td>14</td>
<td>Suitable for IAPT service, but patient declined treatment that was offered</td>
</tr>
<tr>
<td>15</td>
<td>Deceased (assessed only)</td>
</tr>
<tr>
<td>97</td>
<td>Not Known (assessed only)</td>
</tr>
<tr>
<td>16</td>
<td>Incomplete Assessment (Patient dropped out)</td>
</tr>
<tr>
<td>40</td>
<td>Stepped up from low intensity IAPT service</td>
</tr>
<tr>
<td>41</td>
<td>Stepped down from high intensity IAPT service</td>
</tr>
<tr>
<td>42</td>
<td>Completed scheduled treatment</td>
</tr>
<tr>
<td>43</td>
<td>Dropped out of treatment (unscheduled discontinuation)</td>
</tr>
<tr>
<td>44</td>
<td>Referred to non IAPT service</td>
</tr>
<tr>
<td>45</td>
<td>Deceased (assessed and treated)</td>
</tr>
<tr>
<td>98</td>
<td>Not Known (assessed and treated)</td>
</tr>
<tr>
<td>46</td>
<td>Mutually agreed completion of treatment</td>
</tr>
<tr>
<td>47</td>
<td>Termination of treatment earlier than Care Professional planned</td>
</tr>
<tr>
<td>48</td>
<td>Termination of treatment earlier than patient requested</td>
</tr>
<tr>
<td>49</td>
<td>Deceased (Seen and taken on for a course of treatment)</td>
</tr>
<tr>
<td>95</td>
<td>Not Known (Seen but not taken on for a course of treatment)</td>
</tr>
<tr>
<td>96</td>
<td>Not Known (Seen and taken on for a course of treatment)</td>
</tr>
</tbody>
</table>
Questions?

send any questions to: ENGLAND.MentalHealth@nhs.net
Resources

• **What is SNOMED CT**: A4 1 side fact sheet
• **Jargon Buster**: A4 1 side fact sheet:
• **A quick look at SNOMED CT**: short video
• **Introduction to SNOMED CT**: live webinar

• Lots of other resources on our [website](#) including lists of clinical terms
  • **Analytics**: incorporating in database, includes SQL scripts
  • Training for clinical coders: slides and workbook
  • **Case studies**

• Helpdesk: [snomedmentalhealth@nhs.net](mailto:snomedmentalhealth@nhs.net)
Big picture: a connected NHS

Clinician to clinician communication

- Improve care
- Reduce Burden
Local picture:
How can you / your organisation use data to improve processes and care?
A ‘business case’ for SNOMED & EPR

• 12% of all primary care patients may be affected by a prescribing or monitoring error over the course of a year, increasing to 38% in those 75 years and older and 30% in patients receiving five or more drugs during a 12-month period. (WHO 2016)

• Is this new innovative ‘intervention’ being delivered, does it have better outcomes?

• Which intervention produces the better outcomes for patients with eating disorders; does that change with age?

• We have a central clinical alert team who act when a medication hasn’t been administered, a planned intervention hasn’t been done, a review hasn’t been undertaken, we are about to breach a NICE guideline…
SNOMED CT is:
- recorded at point of care
- provides national clinical terms
- enables data sharing
- enables decision support
- enables graphing

Enables accurate recording of patient care related information – it's not at a summary level

- Thoughts of self harm
- Cognitive behavioural therapy
- Referral to mental health team
- Body weight
- Attends smoking cessation clinic
- Family history: schizophrenia
- Suspected drug abuse
We’re on a journey ….  

What to capture in SNOMED  
What added value does it give  

Current NHSE priorities:  
• Outcomes  
• Interventions
Analysis can improve care

This analysis could only be undertaken once they adopted SNOMED CT, they recorded symptoms and patient issues; it revealed things they ‘knew’ but hadn’t realised.

This resulted in change & simple interventions that improved care
Time to reflect - What data is helpful to you?

- A graph of the last 3 months of patient's body weight
- My clinical audit data at the press of a button
- Reduced effort to submit national data ‘£1 to 1p’
- Patients co-morbidities clearly in view

Health Services

Health Services Data Set (MHDS) services the care of children, young people and contact with mental health autism spectrum disorder services.
How do clinical Terms get in SNOMED CT

• Large amount of content came originally from CTV3 – so determined by phrases clinicians wanted

• You can request terms you need

• We are asked to create terms to support NICE guidelines e.g. CBT ED

• To support national programmes e.g. bowel cancer screening, immunisations, flu vaccines, new born blood spot screening ….

• To support international initiatives eg genomics

• To keep abreast of current patient care needs

• It is an international effort
What is the requirement?

• Requirement is in relation to the management of patient care
• For all NHS, by April 2020
• EPR needs to support SNOMED:
  • contracts with suppliers require ISN compliance. SNOMED has an ISN
  • ISN will apply in provider contracts from April 2020
• eDischarge requires procedures, diagnosis, allergies, medications
• GPs enter data in the record using SNOMED for key data such as procedures undertaken, diagnosis, outcomes, allergies, medications, family history, observations ...
• Organisations analysing data need capability to be able to analyse (for eg) data captured using SNOMED
• IAPT is moving to extracting data from the EPR rather than requiring additional ‘coding’ – this enables IAPT services to accurately reflect what they do, which will aid both local and national reporting
Current Approaches

• SNOMED enabled system
  • Should be recording data at the right level for patient care
  • Templates ensure the right SNOMED codes are entered, but may also restrict data entry – so may need to review

• Mapping from local codes
  • Ensure selecting codes to map to from the correct SNOMED hierarchy
  • Ensure providing the codes detailed in guidelines eg NICE
  • May need to be at a higher level to start
  • Use clinicians to validate maps – and does help to engage clinicians
Mapping local codes

• Stage 1:
  • Convert local keyword lists to SNOMED: mindful often categories
  • Workshop: support clinical leads to get ‘starter’ list of SNOMED terms
• Stage 2
  • Identify Clinical champions to engage other clinicians
  • Train clinical coders in SNOMED, can support quality of SNOMED record

• In SNOMED EPR, Clinicians find the terms they want to record

• ICD-10 and OPCS-4 categorise an FCE, still required standards
What about Historical data?

Longitudinal reports?
Current local codes?

For info: in general practice we mapped all historical data to SNOMED CT.
Current observations from MHSDS

• Concepts are being recorded from a range of hierarchies, some inappropriate for the table, as well as invalid codes

• Codes need to be the Concept ID

• Codes in SNOMED code can become inactive, these will stop being available for data entry so need to be addressed.

• Terms such as Procedure, Evaluation Procedure, Treatment, Review I would suggest are not appropriate terms

• Rule of thumb: is this helpful to another clinician, remember SNOMED is not about categorising the care but about sharing key data

• For more information on SNOMED hierarchies see our Fact Sheet
Some examples …

• We are starting data quality reviews so here’s a few to think about:
  • Substance is a substance, so Alcohol is the substance Alcohol. Did you mean: Alcohol abuse prevention education (procedure) or possibly Education about alcohol consumption (procedure)
  • Physical Object: Device is not an intervention but groups all devices; Aids to daily living are the actual devices. Did you mean: Assistive device education (procedure)
  • Religion is the person’s religion, not to be recorded in procedures
  • Disorder is the diagnosis e.g. Autistic Disorder and should be in the diagnosis table.
Helpdesk: snomentalhealth@nhs.net

Connect with us

@nhsdigital
company/nhs-digital
www.digital.nhs.uk

Information and technology for better health and care
IAPT Provider & System Suppliers Event

IAPT Workforce Coding, Data Quality and Guidance

Nick Armitage - Analytical Section Head, Workforce Statistics, NHS Digital
workforce.standards@nhs.net / n.armitage@nhs.net
Aims:

• To give context to the need for workforce information and to make the case for its importance

• To introduce the work of the Mental Health workforce information subgroup

• To provide an outline of the guidance, communications and data quality testing under development for the coding of IAPT workforce information

• To give a plug for the workforce Minimum Data Set for Independent IAPT providers…

• To gain your support!
Why workforce information?

• The Five Year Forward View for Mental Health set out the improvements in mental health services by 2021. All underpinned by the workforce.

• Stepping Forward to 2020/21: The Mental Health Workforce plan for England, states that to achieve the net growth in staff, service providers, service commissioners, local authorities and the third sector will need to work together, supported by the national Arm’s-Length Bodies.

• More recently the development of the Mental Health Implementation Plan puts even more focus on an appropriately trained, recruited, retained (and where necessary) retrained workforce being available to deliver key areas of mental healthcare.

• Linked to these initiatives, IAPT services continue to expand – including increased delivery in Primary Care settings

• In order to deliver and monitor progress in relation to these recommendations, HEE and NHSE/I are undertaking analysis of the Mental Health workforce employed by the NHS and Independent Healthcare providers.

• To supplement data extracted from the NHS Electronic Staff Record (ESR) system, they are relying on a series of ad hoc workforce surveys for the NHS and services commissioned by the NHS but not directly employed by the NHS.

• By enhancing the data held in ESR for the NHS MH workforce and encouraging Independent Mental Health providers to submit the workforce Minimum Data Set (wMDS) we can ensure that this data is available on a routine and consistent basis; collected once and used for multiple purposes to reduce the burden of completing ad hoc surveys.
The MH Workforce Information sub-group

- A Mental Health Sub-Group of the Workforce Information Review Group (WIRG) was set up to agree a definition for the Mental Health Workforce.

- Chaired by the DHSC, it involves representation from the Arms Length Bodies (ALBs) interested in the MH workforce and also NHS MH Trusts.

- With the definition agreed, it’s focus is on the ALBs working together to ensure accurate and high quality workforce data on the MH workforce is available for the NHS and the Independent sector.

- Four strands of work:
  - Guidance;
  - Communications;
  - Updates to the data standard;
  - Data quality feedback
What are the data standards?

- The National Workforce Data Set (NWD) and the NHS Occupation Codes provide the basis for healthcare workforce information.
- They include a wide range of data items, such as Job Role, Area of Work, Occupation Code, Full Time Equivalent, Assignment Status, Contract Type, Equalities information etc.
- NHS Digital, NHS E/I, HEE, and others have developed updates for the NWD relating to the Psychologists and the Psychological Therapists and the wider MH workforce.
- These updates are being made available in systems such as ESR in 3 tranches – the most recent being March 2019, and the next update being the end of December.
- The changes will greatly improve the information that relates to important aspects of the MH workforce – including improving the detail on the settings in which mental healthcare is provided and especially the detail available for IAPT services.
- The next stage is to develop and promote detailed guidance to increase the consistency in use of these values.
Guidance and Communications

- Developing an IAPT workforce data manual – set for release before Christmas.

- Planned Indicative Job Title Guide.

- Once published – available here: NWD Guidance

- Guidance for the whole MH workforce under development – IAPT to form a ‘chapter’, to be released before the end of March 2020

- Communications:
  - NHS HRDs and CEOs;
  - Workforce Information / HR specialists;
  - Clinical Managers / Clinical Networks;
  - Independent Healthcare providers

- Face to Face events in early 2020?
Occupation Codes for the Adult IAPT Workforce:

- **S1M** – code reserved for **High-Intensity Therapist** staff in IAPT services only. Previously included both High-Intensity Therapists and Psychological Wellbeing Practitioners, updated guidance moves PWPs to S5M.

- **S8M** – code for both **Trainee High-Intensity Therapists** and **Trainee Psychological Wellbeing Practitioners**.

- **S5M** – code for **Psychological Wellbeing Practitioners** – though other staff may also be coded there, whilst PWPs are not Assistant Practitioners they are broadly operating at that level.

- **S1L** – code reserved for **Applied Psychologists** working **in IAPT services only** – likely to be small numbers whilst coding is updated, and unlikely to be of the order of the other IAPT staff even once updated.
• **Job Roles for Adult IAPT services:**

  • The Job Roles are contained in Staff Groups, and take the format of **Staff Group | Job Role**, the most important values for IAPT services are:
    
    • Additional Professional Scientific and Technical | High Intensity Therapist
    • Additional Professional Scientific and Technical | Trainee High Intensity Therapist
    • Additional Clinical Services | Psychological Wellbeing Practitioner
    • Additional Clinical Services | Trainee Psychological Wellbeing Practitioner

  • These values should be used in combination with Occupation Code and Area of Work to provide further detail.
• **Job Roles related to the wider IAPT team:**
  - Additional Professional, Scientific and Technical | Counsellor
  - Additional Professional, Scientific and Technical | Social Worker – Psychological Therapist
  - Additional Professional, Scientific and Technical | Play Therapist
  - Additional Professional, Scientific and Technical | Family Therapist

• All of the above need to meet the formal definition of a **Psychological Therapist**, having completed one year of recognised full-time (or equivalent part-time) psychological therapy or counselling training leading to a qualification, certification or accreditation recognised by a relevant professional or regulatory body.…

• More detail on the definition is included in the [NHS Occupation Code Manual](#) on the ‘S – S,T&T p5 Tab’.
Job Roles for members of the wider IAPT who do not meet the definition of a Psychological Therapist:

- Additional Clinical Services | Employment Support Worker or Advisor
- Additional Clinical Services | Family Therapist

There is a specific Area of Work value for IAPT services – ‘Mental Health | Mental Health Primary Care | Mental Health Primary Care – IAPT’

Many other AoW values exist to allow capture of the wider MH workforce in other settings or linked to other services, which may also apply to IPAT staff and services, for example:

- Mental Health | Mental and Physical Health Integrated Care | Mental and Physical Health Integrated Care
- Mental Health | Mental Health | Mental Health Perinatal Care

The Manual also includes details on other key themes such as Professional Registration and Location information, for example how it is possible to identify where an IAPT service is being delivered in a Primary Care setting.
Improving data quality / updating the NWD

- Involve individual organisations – ownership of the data
- Understand the barriers
  - Awareness
  - Resource and capacity issues
- Work with data standards and data collection systems
  - Data standard reflects real world, responsive to change – more updates to the NWD?
  - Validation at source;
  - Systems working for users;
  - Bespoke data quality reports;
- Positive and negative feedback on data quality – consequences
- Data available and useful to a wide audience
What is the wMDS?

- The workforce Minimum Data Set (wMDS) was created as an outcome of the Workforce Information Architecture recommendations published by the DHSC.
- It is a Biannual data collection for Independent Healthcare Providers – for data as at the end of March and September each year.
- For those Social Enterprises / Community Interest Companies who use the Electronic Staff Record (ESR) system the information is extracted from the ESR data warehouse directly.
- Four elements to the wMDS collection:
  - Staff Details – characteristics about individual staff and their roles;
  - Registrations – professional registration information as required;
  - Absence – individual absence information; and
  - Vacancies – details of vacant posts which are being advertised.
- Guidance provided by NHS Digital on fields which are required (crucial) and the available values – based on the National Workforce Data Set and the NHS Occupation Codes.
How is it collected and what happens to the data?

- Uploaded via the workforce Minimum Data Set Collection Vehicle (wMDSCV) as an excel template (4 tabs) or 4 separate CSV templates.

- Uses NHS Digital Single Sign-on for secure access and is simple and user friendly.

- The system is secure and includes validations / DQ reports, also includes previous submission information and allows for test submissions to support users.

- Collection windows open in October and April, with one month to submit data.

- Official Statistics published twice a year as Independent Healthcare Provider Workforce Statistics – aggregate data, no identification of individuals

- New and developing publication, includes:
  - Detailed footnotes and caveats – avoid misinterpretation;
  - Characteristics of the workforce – full time / part time, age / gender / ethnicity & nationality;
  - Desire to provide information related to Vacancies

- Increasing number of MH providers submitting the data, including IAPT providers – want to make March 2020 the biggest collection yet!
And finally…

- Increasing interest in workforce information – especially for Mental Health / IAPT.
- Need for consistent and available data to support meaningful Workforce planning, but wish to avoid burden on individual organisations.
- Information is only as good as the data which is input and the systems and standards which are used to capture it – developing guidance and communications so we can all work together to get the most out of what we have!
- Additional guidance and DQ checking available – just ask!
- Good quality workforce information in ESR and wMDS will avoid the need for separate workforce related data collections about IAPT services.
- Your input is welcomed to enable further improvements to the capture of information about evolving roles within Mental Health provision.
- Please get involved and help improve workforce planning for IAPT Services – if not you, please pass on the message to workforce / HR colleagues & those who contract with IHP partners.
IAPT Data Set v2: Perinatal mental health
Perinatal mental health (PMH)

• Between 10–20% of women develop a mental illness during pregnancy or in the first year after delivering their baby
• Women with a history of mental health illness are at significant risk of relapse during pregnancy
• Fathers and partners/carers of women experiencing mental illness during the perinatal period are at an increased risk of developing mental ill-health
• Perinatal mental ill-health includes a wide range of disorders, with post-natal depression affecting 10–15% of women after birth

A large proportion of women who experience mental illness such as depression and anxiety for the first time or see a deterioration in an existing condition during the perinatal period would be appropriate for treatment in IAPT

Source: LSE and Centre for Mental Health, The cost of perinatal mental health problems (2014)
Specialist support for women experiencing moderate/complex–severe mental health problems

- **The Five Year Forward View for Mental Health** set the ambition that women in all areas of England should be able to access evidence-based specialist support, in the community or through inpatient mother and baby services, closer to their home, when they need it.

- **The NHS Long Term Plan** will invest over £950 million over the next five years to support expanding specialist perinatal mental health services to see 66,000 women p.a. by 2023/24.

- Since April 2019, **there is a specialist community perinatal mental health service in every CCG/STP area of England.**

- **19 inpatient Mother and Baby Units (MBUs) across England.** Four new MBUs opened in areas of particular need in the last 24 months (North West, South West, South East Coast and East of England)

- **Over 700 new staff recruited** into specialist community PMH services.
IAPT Manual: The Antenatal and Postnatal Mental Health NICE guideline recognises the serious impact of undiagnosed depression and anxiety disorders on the health and wellbeing of the mother and baby during pregnancy and the postnatal period. Therefore, it is recommended that women in the perinatal period are prioritised for assessment within 2 weeks of referral and commence treatment within 4 weeks.

IAPT & Perinatal Mental Health

• Last year there were 1.6 million referrals to IAPT*

• There were 625,651 live births in England in 2018*

• Depression and anxiety are the most common mental health problems during the perinatal period. Depression and anxiety affects 15-20% of women in the first year after childbirth

• During pregnancy and the postnatal period, anxiety disorders, including panic disorder, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and tokophobia (an extreme fear of childbirth), can occur on their own or can coexist with depression

• Individuals are in the perinatal period for 33 months (9 month pregnancy + 24 months post birth)

* IAPT 2018/19 annual data published by NHS Digital
*NICE Antenatal and postnatal mental health: clinical management and service guidance
*Office of National Statistics (NOMIS):
https://www.nomisweb.co.uk/query/construct/components/stdListComponent.asp?menuopt=12&subcomp=100
IAPT v1.5: Current position

- Work carried out by NHS Digital found that some IAPT services are already using a perinatal flag or other forms of reporting however data was inconsistent and sporadic.
- Some IAPT services had no way to identify women/partners in the perinatal period.
- Whilst the data linkage between the IAPT/Maternity data sets can help to identify the number of women entering treatment, data only becomes available retrospectively. Locally this data is not useful in ensuring quality of care at the immediate point of delivery.
IAPT v2: PMH Flag

- At the point of referral
- Applies to both men and women

**Pregnancy**
Are you pregnant?
Is your partner pregnant?

*Item to accommodate pregnancy where they are not biological parents i.e. surrogacy.*

**Children**
Do you have a child under 12 months old
Do you have a child under 24 months old

Guidance to follow
1. Supporting good clinical practice

Immediately identify individuals (women and men) in the perinatal period at the point of referral. Ensure the most appropriate clinical response

• Prioritised for assessment
• Commencing treatment within 4 weeks
• Allocation of the most relevant practitioner (e.g. PWP perinatal champion)

Building on the excellent work already happening in some IAPT services - perinatal champions, anxiety and depression groups for new parents, etc.

2. Meeting the needs of the local community

Commissioners and providers must fully understand demographic profiles and epidemiological data for their local community in order to provide appropriate IAPT services for the whole population including mothers, fathers/partners during the perinatal period.

3. Robust reliable data

Inserting a mandated field into the data set will vastly improve the availability and quality of data providers and commissioners can use to evidence services are meeting the needs of individuals in the perinatal period in their community, and directly support service development and quality improvement.
IAPT v2: Benefits of a PMH Flag

• **FYFVMH - IAPT:** By 2020/21 it is expected that an extra 600,000 adults with depression and anxiety disorders will be able to access evidence-based (NICE-recommended) psychological therapies each year.

• **NHS LTP - IAPT:** further increase access to IAPT services to 25% of those in need.

• There are a number of barriers that may prevent women accessing services during the perinatal period such as stigma/practicalities during/post birth.

• Men are still under represented in IAPT services.

• **Increasing access for new or expectant parents is important to consider in plans for increasing access into IAPT and achieving the IAPT LTP access ambitions.**
Questions
• Employment support is an integral part of the IAPT service model, that states that there should be one employment adviser for every eight therapists. Prior to EA in IAPT this commitment has not been adequately resourced.

• In 2015 IAPT services had employment support capacity of only 127 WTE compared to a therapist capacity of nearly 7,000 WTE. A ratio of 1 to 54 not 1 to 8.

• EA in IAPT set up to provide the resources so that employment support can be routinely offered to IAPT clients who wish to receive it in 40% of CCGs in England.

• The provision of EAs makes it possible for IAPT services to provide a combined offer of psychological treatment and employment support to enable IAPT clients to remain in, get back to and find work.

• The first new EAs started work in June 2017. EA in IAPT has invested over £35 million to provide over 400 EAs to work in IAPT services in about 40% of CCGs in England.

• We are evaluating whether the provision of combined IAPT treatment and employment support can help IAPT services achieve better mental health and employment outcomes for clients and sustain these outcomes after they are discharged from treatment.

• Contribute to closing the employment gap and support the government ambition to get one million people into work by 2027.

• Make a major contribution to the government target to get an extra 29,000 people with mental illness a year receiving employment support by 2021.
Employment Support Data prior to EA in IAPT

- Employment data was not mandatory and very low levels of data were collected and reported.
- Concentration was on providing data to reach target of getting 25,000 people a year off sick pay and benefits
- The target was consistently met and little attention was paid to employment data items

Historic Issues with IAPT Employment data

- Employment support was categorised as IAPT treatment, despite employment support not being a psychological treatment
- Employment advisers were required to collect and report the IAPT PROMS. This requirement was stopped in 2018 after pressure applied by regional clinical leads over concerns about non-clinicians collecting the PROMS.
- This meant that receiving employment support stopped the clock for waiting time. This could underestimate the waits for psychological treatment
- It also meant that people could receive employment support only and be seen as completing treatment, this could have a negative impact on recovery rates
- Employment support was coded as high and low intensity. There is no such thing as high intensity employment support, low intensity for that matter.
- The 25,000 people a year measure was a gross measure, we never measured those who were off sick pay and benefits at the start of treatment who were on sick pay and benefits at discharge from treatment
New Employment Data Items

- To support the evaluation of the EA in IAPT Initiative a number of changes have been made to IAPT MDS to better capture employment support activity in IAPT services
- These changes were set out in the EA in IAPT Data Handbook that was published in August 2017. They included:
  - The specification of people requiring support into three categories:
    1) Those who were not in work and seeking employment
    2) Those in work and off sick
    3) Those in work and working
  - Of those receiving employment support more people are in work than out of work
  - Introduction of presenteeism questions to measure productivity at work
  - Changes to benefits status questions to reflect new benefits including Universal Credit
Presenteeism

Why are we asking these questions:

- Many people we support are not off sick or not working
- The gains to the economy from improving the productivity of those with common mental health problems that are in work are greater than the benefits of getting people back into from sickness absence or into work following economic inactivity

Questions:

7. During the last 4 weeks have there been days in which you worked but during this time were bothered by physical or psychological problems? YES/NO

8. How many days at work were you bothered by physical or psychological problems? (Only count the days at work in the last 4 weeks)

9. On the days that you were bothered by these problems, was it perhaps difficult to get as much work finished as you normally do? On these days how much work could you do on average?

On a scale of 0 to 10. Where 10 means that you were able to do as much work as you normally do. A 0 means that you were unable to do any work on these days.
Summary of Employment Data Changes in V2

What stops?

- Employment Support no longer classified as Therapy, meaning no more waiting time clock stopping and no possibility of people receiving employment support without therapy being included in recovery calculations
- No more Low & High Intensity Employment Support

What’s new?

- Presenteeism questions to measure productivity in addition to work attendance
- Revised employment status and benefits fields including new benefits
- All services reporting employment data items not just those IAPT providers who are part of the EA in IAPT Initiative.
Any Questions?

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Internet Enabled Therapies
IAPT Dataset v2
Background

- Internet Enabled Therapies (IETs) are therapies where part of the clinical content is provided online.
- IETs can achieve comparable results to NICE compliant face-to-face therapy, when the same therapeutic content is delivered online with the support of an appropriately trained therapist.
- Many prefer to access therapy in this way, and it can require less therapist time. It may also help increase access for people less likely to engage in traditional therapy.
- IETs are widely used in IAPT, but the current dataset does not fully capture the activity.
- NHS England have been working with NICE to assess and evaluate products.
Internet Enabled Therapies Evaluation Project

**Selection and assessment stage**
- NICE identifies and assesses digitally enabled therapies that follow NICE recommendations and address a condition seen in IAPT.
- NICE produces an IAPT assessment briefing (IAB) for each technology that is considered provisionally suitable for the programme.
- The IAB includes: content, digital standards, assessment, effectiveness, and cost and resource impact.
- NICE presents IABs to a panel of experts with lived experience, clinical mental health, health economic and data analysis backgrounds.
- The panel uses the IAB to recommend whether the digitally enabled therapy should continue in the programme.

**Development stage**
- The panel may recommend a NICE assessed digitally enabled therapy for further development before being tested in IAPT services.
- NHS England provides funding to digitally enabled therapy developers to support with this.
- NHS England has commissioned mHabitat to support digitally enabled therapy developers during the development phase.

**Evaluation in practice stage**
- On NICE’s recommendation or completion of required development work, suitable digitally enabled therapies will be evaluated by at least two IAPT services for up to two years.
- NHS England identifies the services based on an expression of interest process.
- NHS England has commissioned North of England Commissioning Support Unit (NECS) to oversee this phase.
- Ongoing data collection will determine whether there are improvements in service efficiency, through saving therapist time, and whether patient outcomes are at least as good as those achieved by NICE-recommended, non-digital therapy.
Evaluation data

The evaluation relied largely on routinely captured data with two additions/alterations

1. Identifying where the specific product was being used.
   • We did this by enabling services to record the relevant product at each of the appointments during which the product was the main intervention

2. Capturing the amount of time therapists spent supporting patients with the product
   • IAPT currently collects data on appointment duration
   • IET could involve multiple very brief clinical contact – e.g. a number of text messages, emails and/or web-chats throughout the week.
   • If each of these were recorded as an individual contact, it would vastly inflate the apparent number of sessions and distort service activity data
   • Constrained to the existing fields, we asked therapists to keep a log of the amount of time they spent supporting each patient throughout the week and enter this under one notional weekly appointment
   • However, this is not ideal and in v2 a separate 'therapist time' field will enable this to be captured accurately
Evaluation data continued

- These two additions enable us to look at:
  - Numbers entering and completing IET (as well as non-IET comparator)
  - Recovery, improvement & deterioration rates between first and last IET sessions (as well as non-IET comparator)
  - The amount of time therapists spent supporting patients using IET compared to those in traditional therapeutic interventions (as well as non-IET comparator)
  - Mean, standard deviation and effect sizes for pre and post IET treatment scores (as well as non-IET comparator)
  - Demographic breakdown of those entering and completing IET (as well as non-IET comparator)
Evaluation legacy & v2 updates

• The current project will come to a close in March 2020
• No new products will come through the centrally coordinated evaluation
• Updates to the dataset will allow IETs to be identified at an appointment level, and therapist time to be accurately captured
• This will be via a drop-down list of products, which can be continually updated and will include the name of the specific module being used (e.g. Silvercloud for depression, or Minddistrict for OCD)
• This will effectively mean that products in use in IAPT will be under continuous evaluation, with activity and outcome data on their use being included in national reports.